



**HIPPA  
RELEASE OF PRIVILEGED INFORMATION TO OTHER  
MEDICAL PROVIDERS FOR TREATMENT, PAYMENT,  
AND OPERATIONS**

I, \_\_\_\_\_, authorize the release of certain  
*(Patient's Name)*

demographic and clinical treatment information to other medical providers as necessary for my medical care. I understand that the information being released may contain psychiatric, alcohol, drug information included in, but not limited to, the history and physical/consult. This information will be treated with strict confidence. Reasonable efforts will be used to maintain confidentiality and prevent disclosure of the information except on my behalf or as may be permitted or required by law.

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

*PLEASE  
DATE & SIGN*

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

*The Orthopaedic and Sports Injury Center  
C. Thomas Hopkins, Jr., M.D.  
Bruce Reid, M.D.*